

**DEPARTMENT OF THE ARMY NONAPPROPRIATED FUNDS
APPLICATION TO BECOME A LEAVE RECIPIENT UNDER THE VOLUNTARY LEAVE TRANSFER PROGRAM**

For use of this form, see AR 215-3; the proponent agency is DCS, G1.

PRIVACY ACT STATEMENT

AUTHORITY: 5 USC 2105, Employee; Army Regulation 215-3, Morale, Welfare, Recreation, Nonappropriated Funds Instrumentalities Personnel Policy; Department of Defense Instruction Number 1400.25, Volume 1406.

PRINCIPAL PURPOSE: For Army Nonappropriated Funds regular employees to become a Leave Recipient under Voluntary Leave Transfer Program for medical, or family emergency, or other hardship situations.

For additional information see the Systems of Records Notice A0215-3 SAMR, NAF Personnel Records.
<https://dpcl.dod.mil/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570007/a0215-SAMR/>

ROUTINE USES: There are no specific routine uses anticipated for this form; however it may be subject to a number of proper and necessary routine uses identified in the system of records notice(s) specified in the purpose statement above.

DISCLOSURE: Voluntary; however, failure to provide identifying information may delay or processing of this application.

EMPLOYEE INFORMATION

1. EMPLOYEE'S NAME <i>(Last, First, Middle)</i>		2. EMPLOYEE'S DOD ID NUMBER	
3a. POSITION TITLE		3b. PAY PLAN	3c. GRADE/PAY LEVEL
4. NAME OF ORGINIZATION <i>(Office, Division, Branch, etc.)</i>			5. OFFICE TELEPHONE NUMBER
6. NATURE OF THE EMERGENCY <i>(Check one)</i> <input type="checkbox"/> MEDICAL <input type="checkbox"/> NON-MEDICAL/HARDSHIP SITUATION		7. DATE EMERGENCY BEGAN	8. DATE EMERGENCY ENDED <i>(or is expected to end)</i>

PHYSICIAN OR EXPERT CERTIFICATION

9. CERTIFICATION FROM ONE OR MORE PHYSICIANS, OR OTHER APPROPRIATE EXPERTS, WITH RESPECT TO THE MEDICAL EMERGENCY, OR ANY ADDITIONAL INFORMATION THAT MAY BE REQUIRED TO SUPPORT THE REQUEST AND THE DURATION OF THE ABSENCE FROM WORK. *(Attach supporting documentations)*

EMPLOYEE LEAVE

10. EMPLOYEE'S ANNUAL AND SICK LEAVE BALANCES AS OF END OF LAST PAY PERIOD? _____ ANNUAL LEAVE BALANCE _____ SICK LEAVE BALANCE	11. LEAVE WITHOUT PAY HOURS USED FOR THIS EMERGENCY? _____ HOURS
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EMPLOYEE CERTIFICATION

12a. NAME OF INDIVIDUAL COMPLETING APPLICATION <i>(If employee is not capable of making an application on his/her behalf.)</i>	12b. TELEPHONE NUMBER
13a. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE. <i>(Signature of employee or individual applying on behalf of employee)</i>	13b. DATE SIGNED (YYYYMMDD)

OFFICIAL CERTIFICATION

14a. FIRST LINE SUPERVISOR'S RECOMMENDATION <input type="checkbox"/> APPROVE <input type="checkbox"/> DISAPPROVE	14b. FIRST LINE SUPERVISOR'S SIGNATURE	14c. DATE SIGNED (YYYYMMDD)
15a. APPROVING OFFICIALS DECISION <input type="checkbox"/> APPROVE <input type="checkbox"/> DISAPPROVE	15b. APPROVING OFFICIALS SIGNATURE	15c. DATE SIGNED (YYYYMMDD)